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	175448	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility reported a census of 56 residents and the sample included 21 residents. Based on record review, observation and interview, the facility failed to provide an individualized plan of care for residents (#42 and #87) and dental for resident (#60). Findings included:	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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- The quarterly Minimum Data Set (MDS) 3.0 assessment for resident #42 dated 10-19-2013 documented the resident had a stage 1 or greater pressure ulcer and had one or more unhealed pressure ulcer(s) at stage 1 or higher. Dated 9-22-2013, the resident had a stage 2 pressure ulcer with granulation tissue present. He/she had a pressure reducing device for his/her bed and was on a turning or repositioning program, received pressure ulcer care and application of a nonsurgical dressings.

The Care Area Assessment pressure ulcer dated 4-22-2013 documented the resident was at risk for skin breakdown with a reddened spot on his/her coccyx.

The care plan at risk for pressure ulcers and other skin impairments such as skin tears/bruises due to history of stage 2 open blister to right buttock dated 10-22-13 documented interventions for staff to assist the resident to reposition in bed as the resident allowed, staff to attempt to reposition the resident at least every 3 hours during the night. Resident to use pressure reducing mattress, gel cusion in his/her recliner to reduce pressure. Dated 10-31-13, staff to reposition the resident frequently and toilet.

Observation on 11-26-13 from 10:59 A.M. to 11:33 A.M. revealed the resident sat in his/her recliner in his/her room watching television. At 11:34 A.M. staff assisted the resident to the bathroom with wheeled walker and gait belt. The resident wore an incontinent product and was incontinent of urine. At 12:03 P.M. the resident ambulated with a wheeled walker, one staff assist from his/her room to the dinning area and sat in

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the chair by the table. The staff placed the pressure relieving cushion in the chair before the resident sat.

Observation on 11-27-13 from 7:18 A.M. to 8:34 A.M. revealed the resident sat in a chair in the television room area. At 8:35 A.M. the resident ambulated to his/her room from the television room area with 2 staff assist, wheeled walker and gait belt. Staff assisted the resident to the toilet. The resident was incontinent of urine. The resident had a pressure sore to right buttock. The pressure sore was open, no drainage observed, and the wound bed was red in color. The pressure area measured: 2 centimeters (cm) x 2 cm with no depth. Licensed staff K cleansed the area with prescribed solution and applied a new dressing treatment.

Interview on 11-27-13 at 1:35 P.M. with direct care staff T revealed it was easy for day shift to make sure the residents were changing positions as they have two meals. The resident walked frequently. Direct care staff T was unsure during the night but assumed staff turned him/her every two hours. The resident could become aggressive/threatened to hit staff, at least two times a week. The certified nursing assistants charted on him/her every shift as his/her behaviors are to be charted on every shift. The resident's family provided a one on one sitter Monday through Friday during the day that took care of most his/her needs. The resident did have behaviors during the day and yelled, tried to hit staff and became violent. When his/her caregiver was not here, staff keep a close eye on him/her as he/she tried to get up and walk with no assistance and forgot his/her walker. The certified nursing assistant the resident had a chair alarm

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so staff knew when he/she got up but was not implemented at this time. The resident came out to meals and the certified nursing assistant said he/she generally ate 100 percent (%) of his/her meals 90% of the time if he/she liked it, and if he/she did not like it he/she told staff.

Interview on 11-27-13 at 1:29 P.M. with licensed staff K revealed the resident was admitted on the unit with the pressure sore. The pressure sore healed then it reopened. Staff repositioned the resident frequently. The resident's care giver took him/her for walks. The resident was on a repositioning schedule but was not specific to what times.

The facility provided Center for Medicare and Medicaid Services (CMS's) Resident Assessment Instrument (RAI) Version 3.0 Manual Chapter 4: Care Area Assessment Process and Care Planning dated June 2010 documented the comprehensive care plan must include measurable objectives and time frames and must describe the services that were furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The facility failed to develop an individualized plan of care specifically repositioning for this resident.

- Resident #87's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 9-25-13, documented the resident's Brief Interview for Mental Status score (BIMS) was 15, which indicated the resident was cognitively intact. The resident required extensive assistance with activities of daily living (ADLs) for bed mobility, and toilet use. The resident required limited assistance of staff with transfers, ambulation, dressing, and personal

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hygiene. The resident was incontinent of urine and bowel and was on a toileting program.

The Incontinence Care Area Assessment (CAA) dated 6-27-13 documented the resident admitted to the facility with an indwelling Foley catheter. The resident had acute kidney failure. The facility removed the catheter on 6-25-13. The resident had occasional incontinence of urine, required extensive assistance of staff for toileting, had a urinary tract infection (UTI), and received an antibiotic for the infection.

The 9-25-13 Care Plan documented the resident had functional incontinence related to his/her physical and mental impairment (was not alert and oriented to person, place, and/or time), had occasional bladder incontinence, chronic kidney failure, received diuretic medication (medication used to remove excess fluid from the body), had diabetes mellitus (when the body cannot use glucose, there was not enough insulin made or the body cannot respond to the insulin), and a pelvic mass. The care plan documented the resident required extensive assistance of one staff for toileting before and after meals, at bedtime and as needed. Staff applied a moisture barrier cream to protect the resident's skin from incontinence. The care plan directed staff to offer fluids at meals and at bedside, prompt with hygiene cues, and encourage a night light for evening toileting. The care plan documented staff provided a quarterly bowel and bladder screening, monitored the resident for signs and symptoms of a UTI, and the resident participated in the dignity incontinence program.

The 10-16-13 bladder screening assessment documented the resident had an indwelling Foley

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catheter. The record lacked any evidence the facility assessed the resident's voiding pattern.

Observation on 11-27-13 at 7:46 A.M. revealed the resident in bed in his/her room. Direct care staff U entered the resident's room, assisted the resident to the edge of the bed, placed a gait belt around the resident, and assisted the resident to a standing position. The resident used a walker to ambulate into the bathroom. On the way to the bathroom, the resident's brief fell down to the floor. Direct staff U sat the resident on the toilet and the resident urinated. At this time direct staff U stated the resident's brief was wet.

On 11-26-13 at 1:32 P.M. during an interview with the resident, he/she stated he/she told staff when he/she needed to go to the bathroom, used his/her call light and staff assisted him/her to the bathroom.

On 11-26-13 at 2:10 P.M. direct care staff S stated the resident was usually wet in the mornings when he/she got the resident up and was not always able to tell staff when he/she needed to go to the bathroom. He/she said if staff asked the resident, then the resident would respond with a "yes" or "no", but did not voluntarily tell staff he/she needed to go to the bathroom. Direct care staff S stated he/she toileted the resident upon arising, after meals, and often the resident's brief was wet. Direct care staff S stated the resident was not on a toileting schedule, they asked the resident if he/she needed to go to the bathroom.

On 11-27-13 at 7:46 A.M. during an interview, direct care staff U stated he/she toileted the resident before and after meals and as needed

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and the resident told him/her when he/she needed to go to the bathroom.

On 11-26-13 at 1:19 P.M. during an interview, licensed staff L stated the resident was able to tell staff when he/she needed to go to the bathroom, but did not use his/her call light to alert staff. He/she stated staff asked the resident before and after meals and when in his/her room if he/she needed to go to the bathroom, then the resident told staff if he/she needed to go to the bathroom. He/she stated he/she updated the care plan with acute changes as needed.

On 11-27-13 at 7:59 A.M. during an interview, licensed nurse M stated staff toileted the resident during the night around 11:00 P.M., 2:00 A.M., and 6:00 A.M. The resident wore incontinence briefs and was incontinent. He/she stated it was too hard for the resident to get out of bed for staff to take him/her to the bathroom at night, so they just checked the resident for incontinence.

On 11-27-13 at 1:26 P.M. during interview, administrative licensed nurse E stated staff assessed each resident's incontinence individually as they became familiar with the resident. He/she stated the resident used dignity briefs (specialized briefs that wick moisture away from the skin). He/she stated staff should toilet the resident during the night also.

The June 2010 facility provided Center for Medicare and Medicaid Services (CMS's) Resident Assessment Instrument (RAI) Version 3.0 Manual Chapter 4: Care Area Assessment Process and Care Planning dated June 2010 documented the comprehensive care plan included measurable objectives, time frames and

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described the services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The facility failed to develop and individualized comprehensive care plan to address the resident's incontinence needs.
- The quarterly Minimum Data Set 3.0 (MDS) dated 9/6/13 for resident #60 recorded he/she had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe impaired cognition.

The resident inventory list dated 2/27/13, untimed, lacked documentation of dentures.

Nursing note dated 3/14/13 at 1:17 P.M documented the resident's dentures were reported missing.

The review of oral assessment dated 3/21/13 at 12:00 P.M noted resident had dentures that fit and the front lower teeth were chipped with some missing.

The Abnormal Involuntary Movement Scale (AIMS) dated 9/5/13 documented resident usually wore dentures.

The care plan dated 9/10/13 for assistance with eating, revealed a dental consult per resident's request and physician orders. The care plan lacked evidence the resident did not have his/her upper dentures.

Nursing note dated 11/12/13 at 8:51 P.M revealed the resident wore an upper partial denture.

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F 279	Continued From page 8 Nursing call list dated 11/25/13 and untimed, noted the resident wore upper partial denture. On 11/26/13 at 10:25 A.M the resident laid in bed with mouth open and no upper dentures present. On 11/26/13 at 11:19 A.M direct care staff J and R assisted the resident out of bed and into a wheelchair. Direct care staff R then pushed the resident into bathroom where the resident brushed his/her teeth with set up assistance. Interview with direct care staff Q on 11/26/13 at 8:25 A.M stated the resident did not wear dentures. Interview with licensed staff J on 11/26/13 at 9:30 A.M stated the resident did not have dentures on admission. Interview with staff J on 11/26/13 at 9:57 A.M stated care plans were up dated as needed by administrative nursing staff D Administrative nursing staff D on 11/26/13 at 10:00 A.M stated he/she updated care plans quarterly. The facility policy for Care Plan Development dated June 2010 recorded the assessment must accurately reflect the resident's status, and the resident's needs were used to develop, review, and revise each resident ' s comprehensive plan of care. The facility failed to develop a comprehensive plan of care for this resident's dental status.	F 279		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 56 residents. The sample included 21 residents. Based on observation, record review, and staff interview the facility failed to prevent the re-opening of a pressure ulcer for 1 resident (#42) of 3 reviewed for pressure ulcers.

Findings included:

- The quarterly Minimum Data Set (MDS) 3.0 assessment for #42 dated 10-19-2013 documented the resident needed extensive assistance with 2 person physical assist with bed mobility, transfer, dressing and toilet use. The resident needed supervision with one person physical assist with walking in room, eating, and personal hygiene. The resident needed limited assistance with one person physical assist with walking in corridor and locomotion on unit. The resident needed one person physical assist and was totally dependent with bathing. The resident was not steady, but able to stabilize without human assistance for balance during transitions and walking. The resident had no impairment in

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range of motion. The resident used a walker for mobility device. He/she had a stage 1 or greater pressure ulcer and had one or more unhealed pressure ulcer(s) at stage 1 or higher. Dated 9-22-2013, the resident had a stage 2 pressure ulcer with granulation tissue present. He/she had a pressure reducing device for his/her bed and was on a turning or repositioning program, received pressure ulcer care, and application of a nonsurgical dressings.

The Care Area Assessment pressure ulcer dated 4-22-2013 documented the resident was at risk for skin breakdown related to bowel and bladder incontinence with a reddened spot on his/her coccyx.

The care plan at risk for pressure ulcers and other skin impairments due to bowel and bladder incontinence, history of stage 2 open blister to right buttock dated 10-22-13 documented interventions for staff to keep the resident's skin clean, dry and well lubricated. Staff to assist the resident to reposition in bed as the resident allowed, and to attempt to reposition the resident at least every 3 hours during the night, have a pressure reducing mattress and gel cushion in his/her recliner to reduce pressure. An intervention dated 10-31-13 noted for staff to reposition the resident frequently.

The care plan for actual impaired skin integrity documented on 10-22-13 the resident had a stage 2 pressure ulcer to the right buttock and on 11-19-13 staff documented the pressure ulcer was a stage 1. Licensed nurse would assess the resident's wound weekly for healing progress.

The Pressure Ulcer Weekly Review document

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dated 10-16-13 revealed a stage 2 pressure ulcer on the right gluteal area which measured: length 3 centimeters (cm), width 1.75 cm, depth less than (<) 0.25 cm. The wound bed was moist. On 10-25-13 the measurements of the pressure ulcer revealed: length 1.75 cm by width 1.5 cm and by depth <0.1cm. The wound bed was dry. Meausurements dated 11-17-2013 revealed the pressure ulcer length 0.75 cm by width 0.75 cm and by depth 0 cm. The wound bed was dry.

The October 2013 treatment administration record (TAR) documented for staff to cleanse the pressure ulcer to the right buttock with saf-clens (wound cleansing agent), apply wound dressing, and check placement every shift.

The November 2013 TAR record documented on 11-19-13 noted for nursing staff to apply sensicare cream on bilateral buttock and monitor for any change. On 11-25-13, the TAR recorded for nursing staff to monitor the open area on right buttock and apply a wound dressing. The nursing staff to change the dressing every 3 to 7 days and as needed until healed.

The Wound Treatment Orders signed and dated 11-26-13 revealed the wound measurements to the right gluteal area were:length 2 cm by width 2 cm and with no drainage.

Observation on 11-26-13 from 10:59 A.M. to 11:33 A.M. revealed the resident sat in his/her recliner in his/her room watching television. At 11:34 A.M. staff assisted the resident to the bathroom with wheeled walker and gait belt. The

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resident wore an incontinent product and was incontinent of urine. At 12:03 P.M. the resident ambulated with a wheeled walker, one staff assistance from his/her room to the dining area and sat in the chair by the table. The staff placed the pressure relieving cushion in the chair before the resident sat.

Observation on 11-27-13 from 7:18 A.M. to 8:34 A.M. revealed the resident sat in a chair in the television room area. At 8:35 A.M. the resident ambulated to his/her room from the television room area with 2 staff, wheeled walker, and gait belt. Staff assisted the resident to the toilet. The resident was incontinent of urine. Observation revealed the resident had a pressure sore to right buttock. The area was open, no drainage observed, and the wound bed was red in color. The pressure area measured 2 cm by 2 cm with no depth. Licensed staff K cleansed the area with prescribed cleansing solution and applied a new dressing.

Interview on 11-27-13 at 1:35 P.M. with direct care staff T revealed it was easy for day shift to make sure the residents were changing positions as they had two meals. The resident walked frequently. Direct care staff T was unsure during the night, but assumed staff turned him/her every two hours. The resident could become aggressive and threatened to hit staff at least two times a week. The certified nursing assistants charted on him/her every shift as his/her behaviors were charted every shift. The resident's family provided a one on one sitter Monday through Friday during the day who took care of most the resident's needs. The resident did have behaviors during the day and yelled, tried to hit staff, and became violent. When his/her

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F 314	Continued From page 13 caregiver was not here, staff kept a close eye on him/her as he/she tried to get up and walk with no assistance and forgot his/her walker. He/she said the resident had a chair alarm so staff knew when he/she got up but it was not implemented at this time. The resident came out to meals and he/she said the resident generally ate 100 percent (%) of his/her meals 90% of the time if he/she liked it, and if he/she did not like it, the resident told the staff so he/she could get something else to eat. Interview on 11-27-13 at 1:29 P.M. with licensed staff K revealed the resident was admitted on the unit with the pressure sore. The pressure sore healed then it reopened. Staff repositioned the resident frequently and he/she has a gel cushion. The resident's care giver took him/her for walks. The resident was on a repositioning schedule but was not specific to what times. The pressure ulcer occurred on 10-28-13 on the right inner buttock and measured 0.5 cm. The facility provided Presbyterian Manors of Mid-America Operational Policy Skin and Wound Treatment Guidelines revision dated July 2013 documented if the resident was assessed at risk, reposition at least every two hours or more frequently when in bed and at least every hour when in a chair; if alert and capable, the resident should be taught to shift his or her weight every 15 minutes while in a chair. The facility failed to develop and implement effective interventions to prevent the re-opening of an avoidable pressure ulcer for this resident who required extensive staff assistance with repositioning.	F 314		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=D	Continued From page 14 RESTORE BLADDER	F 315		

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 56 residents. The sample included 21 residents. Based on observation, record review, and interview the facility failed to throughly assess and establish a voiding pattern for 2 (#87 and #17) of the 4 residents reviewed for incontinence.

Findings included:

- Resident #87's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 9-25-13, documented the resident's Brief Interview for Mental Status score (BIMS) was 15, which indicated the resident was cognitively intact. The resident required extensive assistance with activities of daily living (ADLs) for bed mobility, and toilet use. The resident required limited assistance of staff with transfers, ambulation, dressing, and personal hygiene. The resident was incontinent of urine and bowel and was on a toileting program.

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The Incontinence Care Area Assessment (CAA) dated 6-27-13 documented the resident admitted to the facility with an indwelling Foley catheter. The resident had acute kidney failure. The facility removed the catheter on 6-25-13. The resident had occasional incontinence of urine, required extensive assistance of staff for toileting, had a urinary tract infection (UTI), and received an antibiotic for the infection.

The 9-25-13 Care Plan documented the resident had functional incontinence related to his/her physical and mental impairment (was not alert and oriented to person, place, and/or time), had occasional bladder incontinence, chronic kidney failure, received diuretic medication (medication used to remove excess fluid from the body), had diabetes mellitus (when the body cannot use glucose, there was not enough insulin made or the body cannot respond to the insulin), and a pelvic mass. The care plan documented the resident required extensive assistance of one staff for toileting before and after meals, at bedtime and as needed. Staff applied a moisture barrier cream to protect the resident's skin from incontinence. The care plan directed staff to offer fluids at meals and at bedside, prompt with hygiene cues, and encourage a night light for evening toileting. The care plan documented staff provided a quarterly bowel and bladder screening, monitored the resident for signs and symptoms of a UTI, and the resident participated in the dignity incontinence program.

The 10-16-13 bladder screening assessment documented the resident had an indwelling Foley catheter. The record lacked any evidence the facility assessed the resident's voiding pattern.

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On 6-19-13 the hospital progress note documented the resident had acute kidney failure, was dehydrated (did not receive enough fluids), needed dialysis (procedure to excrete excess toxins from the blood because the kidneys were not able to do it), but the family declined.

On 11-15-13 the physician progress note documented the resident received Lasix (a diuretic medication) and due to the resident's chronic renal insufficiency, he/she would not increase the dosage to help alleviate some of the resident's increased fluid build-up.

The daily Bowel and Bladder Chart Detail Report used by direct care staff to document when the residents were incontinent of bladder, documented from 6-26-13 through 6-30-13, the resident was incontinent of urine 5 times and all were during the night.

The daily Bowel and Bladder Chart Detail Report documented from 7-1-13 through 7-30-13 the resident had 46 incontinent episodes.

The daily Bowel and Bladder Chart Detail Report documented from 8-1-13 through 8-31-13 the resident had 37 episodes of incontinence.

The daily Bowel and Bladder Chart Detail Report documented from 9-1-13 through 9-30-13 the resident had 53 incontinence episodes.

The daily Bowel and Bladder Chart Detail Report documented from 10-1-13 through 10-30-13 the resident had 31 incontinence episodes. The chart also documented staff provided a bedpan or toileted the resident during the night and had less

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incontinent episodes during the month.

The daily Bowel and Bladder Chart Detail Report documented from 11-1-13 through 11-27-13 the resident had 36 incontinence episodes.

Observation on 11-27-13 at 7:46 A.M. revealed the resident in bed in his/her room. Direct care staff U entered the resident's room, assisted the resident to the edge of the bed, placed a gait belt around the resident, and assisted the resident to a standing position. The resident used a walker to ambulate into the bathroom. On the way to the bathroom, the resident's brief fell down to the floor. Direct staff U sat the resident on the toilet and the resident urinated. At this time direct staff U stated the resident's brief was wet.

On 11-26-13 at 1:32 P.M. during an interview with the resident, he/she stated he/she told staff when he/she needed to go to the bathroom, used his/her call light and staff assisted him/her to the bathroom.

On 11-26-13 at 2:10 P.M. direct care staff S stated the resident was usually wet in the mornings when he/she got the resident up and was not always able to tell staff when he/she needed to go to the bathroom. He/she said if staff asked the resident, then the resident would respond with a "yes" or "no", but did not voluntarily tell staff he/she needed to go to the bathroom. Direct care staff S stated he/she toileted the resident upon arising, after meals, and often the resident's brief was wet. Direct care staff S stated the resident was not on a toileting schedule, they asked the resident if he/she needed to go to the bathroom.

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On 11-27-13 at 7:46 A.M. during an interview, direct care staff U stated he/she toileted the resident before and after meals and as needed and the resident told him/her when he/she needed to go to the bathroom.

On 11-27-13 at 11:18 A.M. during an interview, direct care staff V stated direct care staff did not perform a 3 day voiding diary for any incontinent residents, was not sure how it was determined how often to check or toilet residents.

On 11-26-13 at 1:19 P.M. during an interview, licensed staff L stated the resident was able to tell staff when he/she needed to go to the bathroom, but did not use his/her call light to alert staff. He/she stated staff asked the resident before and after meals and when in his/her room if he/she needed to go to the bathroom, then the resident told staff if he/she needed to go to the bathroom.

On 11-27-13 at 7:59 A.M. during an interview, licensed nurse M stated staff toileted the resident during the night around 11:00 P.M., 2:00 A.M., and 6:00 A.M. The resident wore incontinence briefs and was incontinent. He/she stated it was too hard for the resident to get out of bed for staff to take him/her to the bathroom at night, so they just checked the resident for incontinence.

On 11-27-13 at 11:17 A.M. during an interview, licensed nurse M stated staff monitored the residents for incontinence or just asked the resident. He/she stated staff completed a bowel and bladder assessment to determine the resident's incontinence needs and did not use a voiding diary to assess them.

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On 11-27-13 at 1:26 P.M. during interview, administrative licensed nurse E stated staff assessed each resident's incontinence individually as they became familiar with the resident. He/she stated the resident used dignity briefs (specialized briefs that wick moisture away from the skin). He/she stated staff should toilet the resident during the night also.

The March 2011 facility provided Urinary Incontinence Policy and Procedure documented staff utilized an electronic Screening Bladder and Continence Detail Report to determine the type of urinary incontinence and based on the resident evaluation, determined what program to implement.

The facility failed to assess the resident to establish a pattern to determine how often staff checked or offered toileting to the resident to maintain or prevent a decline in the resident's incontinence.

- The Physician's Order Sheet (POS) for Resident #17 dated 10/31/13 included a diagnosis of carcinoma in situ (malignant cell changes in the epithelial tissue that did not extend beyond the base membrane) of prostate.

The 10/31/13 Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating the resident had moderately impaired cognition; the resident

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required one person physical assist with bed mobility, transfers, and walking in the room and corridor, set up help with locomotion on and off the unit, and 2 person assistance with dressing, toilet use, and personal hygiene. The resident used a walker, was on a toileting program and was frequently incontinent of urine.

The 10/29/13 care plan for functional incontinence related to physical/mental impairment related to diagnosis of bladder incontinence (the inability to retain urine through loss of sphincter control) and history of bladder cancer (uncontrolled growth of cells derived from normal tissue) stated the resident would have a bowel and bladder screen quarterly and as needed, the resident required extensive assist of 1 staff with toileting before meals, after meals, at bedtime, and as needed. The resident to have and use incontinence products and nursing staff to ensure they were used appropriately, changed at toileting times, and as needed; nursing staff would keep the resident's skin well lubricated with moisture barrier, offer fluids of choice at meals and at bedside, assess the residents environment and modify as needed to ensure he/she could safely move to the toilet, encourage the resident to use a night light for evening toileting, monitor the resident for signs and symptoms of a urinary tract infection, participate in the dignity incontinence program, staff to change incontinence products per the manufacturer recommendation and as needed, and staff to encourage the resident to use grab bars when using the toilet.

The quarterly bladder screening assessment dated 10/30/13 showed the resident did not have

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a diagnosis of incontinence, the duration of incontinence was years, the resident's perception of the need to void was diminished, had no apparent voiding pattern, and had functional incontinence.

Record review on 11/26/13 revealed the clinical record lacked a 3 day bladder assessment to identify the resident's voiding patterns.

On 11/25/13 at 7:28 A.M. the resident smelled of urine and there was a wet area on his/her bed sheet.

On 11/26/13 at 8:37 A.M. the resident finished breakfast and ambulated to his/her room. Frequent observations at 8:42 A.M., 8:50 A.M., 9:02 A.M., 9:13 A.M., and 9:25 A.M.,revealed the staff did not assist the resident to the bathroom.

On 11/26/13 at 9:27 A.M. Direct care staff P entered the resident's room and took the resident's roommate to the bathroom. Staff did not encourage or assist this resident to the bathroom. At 9:48 A.M. the resident laid in bed with his/her eyes closed.

Direct care staff P on 11/26/13 at 9:40 A.M. stated the resident went to the bathroom independently but when he/she went to the bathroom, staff followed him/her and saw what he/she did because sometimes the resident applied a clean brief on top of the old one. He/She also stated staff reminded the resident what to do and then he/she could do it. Direct care staff P stated the resident was always wet

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F 315	Continued From page 22 when staff followed him/her into the bathroom. Licensed care staff J on 11/26/13 at 10:52 A.M. stated nursing staff completed bladder screenings prior to the care plan meetings. He/She stated a 3 day voiding diary was not completed on this resident. He/She reported there was no way to establish a voiding pattern on the resident as he/she was independent and took himself/herself to the bathroom. Licensed care staff J also stated nursing staff knew the pattern on other residents because nursing staff were the ones who took them to the bathroom. The facility failed to assess the voiding pattern for this frequently incontinent resident.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 56 residents. Based on observation, and interview, the facility failed to distribute medication to two unsampled residents in a sanitary manner.

Findings included:

- During observation on 11-21-13 at 12:03 P.M. licensed nurse J dispensed several pills from an unsampled resident's blister pak into his/her hand and placed the pills on a paper towel on top of the medication cart. Licensed nurse J put the pills in a plastic packet and crushed the pills, placed them in a food substance and gave the medication to the resident. Licensed nurse J washed his/her hands, wiped his/her nose and removed several pills from a different unsampled

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resident's blister pak. He/she placed the pills in a plastic pouch, crushed the medication, mixed them with a powder substance, went to the kitchenette, removed a dirty dish cart out of the way, opened the refrigerator door, poured juice in a glass, placed the mixture in the glass, removed a straw from its paper wrapping and stirred the mixture with the straw while he/she touched the top end of the straw, and gave it to the resident to drink. The resident drank it through the straw.

On 11-26-13 at 12:20 P.M. during observation, licensed nurse L placed an unsampled resident's medication in a medication cup, rubbed his/her face and removed hair from his/her face then stuck his/her finger inside a plastic pill pouch to open it and poured the resident's medication into the pouch and crushed it.

On 11-27-13 at 10:37 A.M. during interview, administrative licensed nurse E stated the nurse should not have touched the pills, inside of the pouch or the end of the straw with his/her hands.

The facility failed to distribute medications in a sanitary manner to residents in the facility.